SWALLOWING DISORDERS CHECKLIST

NAME: _____ **AGE:** _____ **Residence:** _____

Ideal Wgt Range: _____**Current Weight:** _____ **(M ____F____) (ICF _____ Non-ICF _____)**

Current Diet Orders/Consistency: _____

Must be completed by someone who is familiar with the above named person's eating/dining habits and

MUST BE UPDATED ON AN ANNUAL BASIS.

*Note **Yes** or **No** for each statement; include notes to explain all that are marked **YES**.*

See instructions on reverse side of this page.

DATE: **This person:**	**2009**	**2010**	**2011**	**2012**
1. Coughs consistently before, during or after meals.				
2. Chokes or gags during meals.				
3. Has lost weight or is noticeably under weight.				
4. Refuses or has difficulty with some textures. (liquids, chopped meats etc.)				
5. Sounds wet or gurgly, when breathing or talking before, during or after eating/drinking.				
6. Has frequent colds, congestion, upper respiratory infections, or chronic respiratory problems.				
7. Swallows more than once to clear mouth or struggles to clear mouth of food/liquid.				
8. Takes more than thirty minutes to complete meals.				
9. Refuses to eat or is eating less than they normally would.				
10. ___Vomits, ___regurgitates, or___ belches/burps during or after a meal. (**designate which one & give explanation**)				
11. Hand in mouth behavior noted.				
12. Extends neck/head backwards during meals &/or problems with positioning during meals.				

IF ANY OF THE ABOVE ARE YES, THE *SWALLOWING DISORDERS FOLLOW-UP ASSESSMENT* MUST ALSO BE COMPLETED

Person completing form: _____Phone #: _____ DSN Board: _____
FAX number: _____ Email Address:_____ Date: _____

SWALLOWING DISORDERS CHECKLIST
Instructions for Completing

A staff member who is familiar with the person and their eating/dining habits must complete checklist. Answer all of the questions and provide comments to explain the answers. **UPDATED COPIES OF CHECKLIST SHOULD BE SUBITTED ANNUALLY**

1. **Coughs consistently before, during or after meals:** Does this person cough prior to meals, while eating, or when meal is finished?
2. **Chokes or gags during meals:** Does this person "get choked" on certain foods or liquids? During a specific meal? When eating too fast? Does he/she gag during meals? If so, does this appear to be related to specific foods?
3. **Has lost weight or is noticeably under weight:** Has this person lost weight? If specific weights are not available, does he/she appear to have lost weight? (i.e. is clothing loose?, etc.)
4. **Refuses or has difficulty with some textures (liquids, chopped meats, etc.**): Are there specific foods or liquids that this person always has trouble eating?
5. **Sounds wet or gurgly, when breathing or talking before, during or after eating/drinking**. When speaking or making noises, does this person sound gurgly or congested?
6. **Has frequent colds, congestion, upper respiratory infections or chronic respiratory problems.** Does this person frequently appear to have a cold, cough, sound congested or appear to have breathing/respiratory problems on a regular basis?
7. **Swallows more than once to clear mouth or struggles to clear mouth of food/liquid:** Does this person consistently hold food in their mouth? Is food found in their mouth after the meal has been completed? Does the meal take a long time because the person does not swallow food?
8. **Takes more than thirty minutes to complete meals:** Does this person take an extended amount of time to complete the meal?
9. **Refuses to eat or eating less than they normal.** Is this person refusing to eat one specific meal? One meal per day? Eating only about half of the food served? Eating less than normal?
10. **Vomits, regurgitates, or belches/burps during or after a meal. (DESIGNATE WHICH ONE)** Does this person ruminate (to chew again or over and over) after meals? Regurgitates (returns of partly digested food from the stomach to the mouth) during meals? Spits up after meals? Leans forward or to the side after meals to assist in regurgitation? Belches excessively after meals? Vomits within 2 hours after meals on a consistent basis.
11. **Hand in mouth behavior noted:** Does this person constantly keep hands in mouth? Before, during or after meals? Is this behavior new?
12. **Has problems with positioning during meals:** Difficulty maintaining safe, upright position during meals. **Extends neck/head backwards during meals.** This person consistently throws head back, extends neck in order to getting food/liquid down? When/if consumer does this, are loud swallows or coughing noted.

IF ANY OF THE ABOVE ARE MARKED YES, THE *SWALLOWING DISORDERS FOLLOW-UP ASSESSMENT* MUST ALSO BE COMPLETED